Enclosure 4

FISCAL YEAR 2007-08
PAROLEE SERVICES NETWORK

AMENDMENT TO COUNTY WORK PLAN, EFFECTIVE [FILL IN DATE]

<table>
<tr><td colspan="2">COUNTY:</td><td colspan="2">PROJECT TOTAL ALLOCATION:
$</td></tr>
<tr><td colspan="2">AGENCY:</td><td colspan="2">COUNTY'S ADMINISTRATIVE ALLOCATION:
$</td></tr>
<tr><td colspan="2">ADDRESS:</td><td colspan="2">PROVIDER ALLOCATION:
$</td></tr>
<tr><td colspan="4">ALCOHOL & DRUG PROGRAM ADMINISTRATOR & PSN COORDINATOR:</td></tr>
<tr><td colspan="2">NAME:</td><td colspan="2">NAME:</td></tr>
<tr><td colspan="2">TITLE:</td><td colspan="2">TITLE:</td></tr>
<tr><td colspan="2">MAILING ADDRESS:</td><td colspan="2">MAILING ADDRESS & E-MAIL</td></tr>
<tr><td>PHONE:
( )</td><td>FAX:
( )</td><td>PHONE:
( )</td><td>FAX:
( )</td></tr>
</table>

The County Alcohol and Drug Program Administrator certifies that the county will abide by the contractual terms and conditions contained in Document 1D of the NNA contract. The agency certifies that all fiscal data contained in this work plan are correct and that it intends to incorporate the data into the County's NNA contract.

Signature of County Alcohol and Drug Program Administrator	Typed Name and Title	Date

Form Revised 03/19/07

AMENDMENT TO COUNTY WORK PLAN, EFFECTIVE [FILL IN DATE]

SECTION I
COUNTY WORK PLAN SUMMARY

Summarize total project information for Fiscal Year 2007/08

Treatment Modality	Annual Treatment Allocation	% of Allocation	# of Treatment Slots	# of Units (Bed Days/ Staff Hours)	% of Tx Matrix
a. Detox LT	$			$	
b. Residential	$			$	
c. Non-Residential*	$			$	
d. Sober Living	$			$	
e. Case Management/ Central Intake	**$**			$	
f. Other Services	$			$	
TOTALS	$			$	

g.	* SUMMARY OF SLOTS IN NON-RESIDENTIAL SUBMODALITIES				
Relapse Prevention (1-1/2 – 3 hours over 1 - 3 visits per week)					
Non-Residential (5 hours over at least 3 visits per week)					
Intensive (9 hours over at least 3 visits per week)					
Day Treatment (4 hours at least 5 days per week) *Enclosure 6 p. 2					

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Section IA
COUNTY WORK PLAN
ALLOCATION DISTRIBUTION

Summarize specific provider information for FY 2007/08
Provide an alphabetic list. (Use additional pages as needed)

Distribution by Modality	Cost Per Unit of Service	Units of Service	# of Treatment Beds/Slots	Annual Treatment Allocation Per Provider	Amendment
Detox Programs					
1.					
2.					
Total					
Residential Programs					
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
Total					
S.L.E. Programs					
1.					
2.					
3.					
4.					
Total					
Non-Residential Programs					
1.					
2.					
3.					
4.					
5.					
6.					
Total					
Case Management Central Intake					
Total					
Total Allocation	N/A	N/A	N/A	$	

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Section II
COUNTY WORK PLAN
PROVIDER INFORMATION

Provide specific information on each provider rendering services to the Parole Services Network. Please submit a separate sheet for each provider. Provide all addresses where provider services are rendered, indicate treatment modality provided at each site, including SLE facilities and all other information requested below.

PROVIDER NAME:		CORPORATE ADDRESS:	
PHONE NUMBER:		FAX NUMBER::	
E-MAIL:		CORPORATE CADDS NUMBER:	
NAME OF CONTACT PERSON:			
CORPORATE RESIDENTIAL LICENSE OR ODF CERTIFICATION NUMBER:			
TREATMENT SITE ADDRESSES:	MODALITY	SITE FIN # for client (if applicable)	SITE LICENSE OR CERT NUMBER (if applicable)